Topic: Health Disparities

The elimination of racial and ethnic health disparities have been a concern in segments of the health policy community for many years. A long-stated goal has been to eliminate disparities in six health categories by 2010: Adult immunization, cardiovascular health, cancer care, diabetes, HIV/AIDS and infant mortality.

The term **health disparities** is often used as an umbrella for two related concepts: **Disparities in health,** which refer to differences in health outcomes and status; and **Disparities in health care,** which refers to differences in the preventive, diagnostic and treatment services offered to people with similar health conditions.

In Michigan, as well as nationally, racial and ethnic health disparities exist in the leading causes of morbidity and mortality.

An understanding of social determinants and their potential role in the development of disease is important in reducing disparities in morbidity and mortality.

In Michigan, adult members of racial and ethnic minority groups are less likely than their White counterparts to have completed both high school and college. Studies have shown a direct correlation between education level and understanding the importance of preventive medical care. According to the 2005 Michigan Behavioral Risk Factor Survey, minority residents in Michigan are also more likely to lack health care coverage, less likely to have a personal health care provider, and more likely to report that they were not able to access health care in the last year due to cost.

Michigan Adults, 2005	No health coverage	No personal care provider	Unable to access health care due to cost
Whites	13.1%	12.6%	10.9%
Blacks	18.5%	21.0%	19.6%
Asian/Pacific Islanders	9.0%	29.2%	16.0%
American Indian/Native Americans	31.1%	22.9%	20.1%
Hispanic/Latinos	26.6%	22.6%	18.9%

***What is the Department of Community Health doing* to address disparities?**

The Michigan Office of Minority Health (OMH) was established in 1988 by executive order. In 2004 the Michigan Department of Community Health changed the name of the OMH to the Health Disparities Reduction and Minority Health Section (HDRMH). The HDRMH serves five populations of color: African-Americans, Hispanics and Latinos, Native Americans and Alaskan Natives, Asians and Pacific Islanders and Arab/Chaldeans. The Section's goal is to reduce health disparities by supporting a portfolio of social/behavioral interventions that target populations at greatest risk and provide services that have documented health promotion and management potential. This responsibility is carried out primarily through grants to local health departments and community-based organizations.

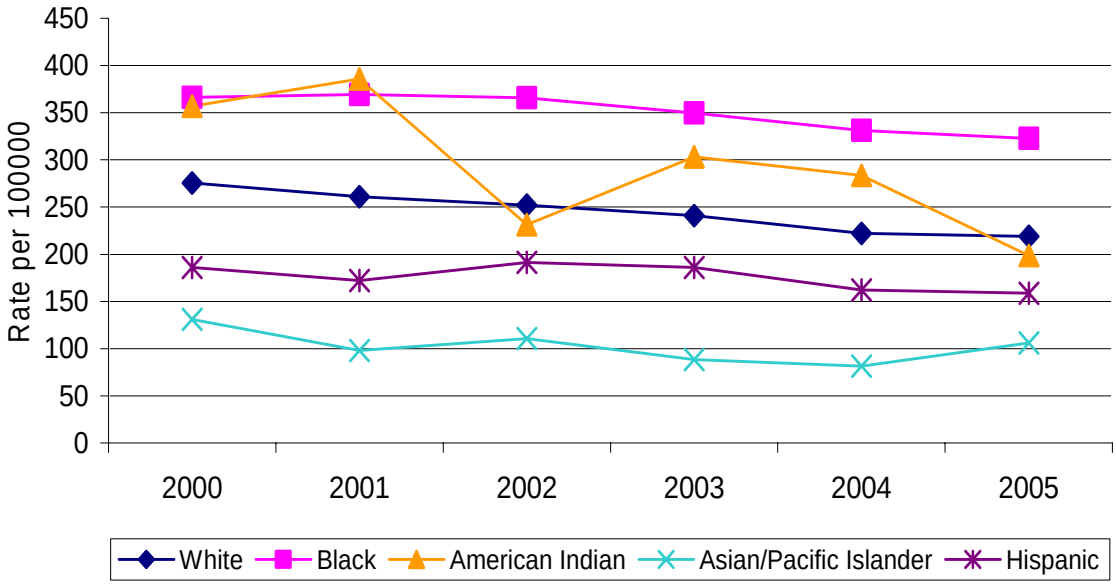
In addition, the Section works to promote and advance the principles published in the 2004 Commonwealth Report which identified eight key areas that state and national policymakers must consider to eliminate racial and ethnic disparities. They include: consistent racial/ethnic data collection; effective evaluation of disparities-reduction programs; minimum standards for culturally and linguistically competent health services; greater minority representation within the health care workforce; expanded health screening and access to services (e.g., through expanded insurance coverage); establishment or enhancement of state offices of minority health; involvement of all health system stakeholders in minority health improvement efforts; and creation of a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities.

Cardiovascular Disease

How are we doing?

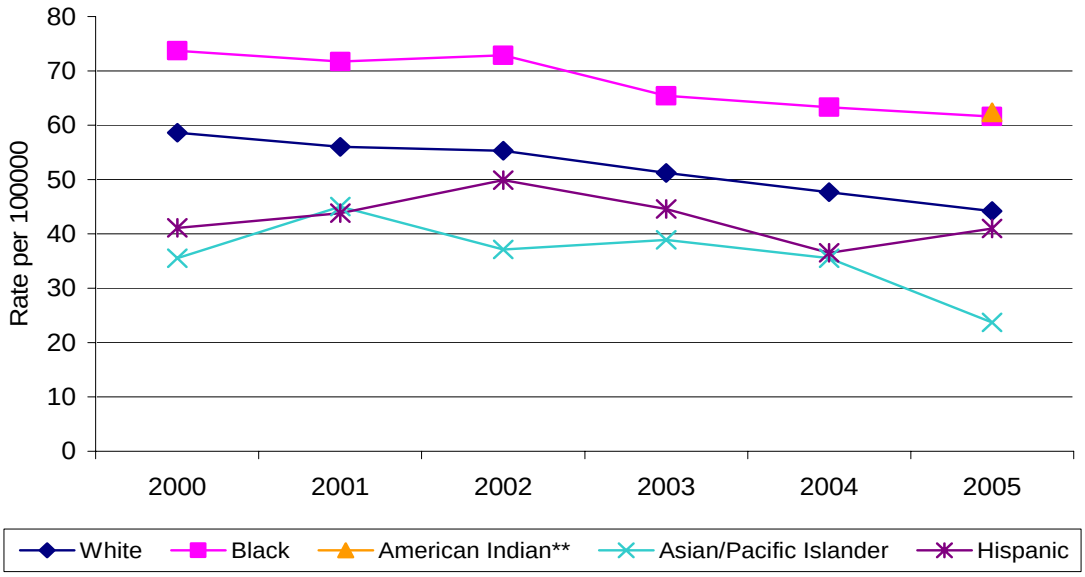
Poor cardiovascular health, in particular, heart disease, is the number one cause of death for all residents in Michigan; however, it is also one area in which disparities can clearly be seen by racial/ethnic population. For example, Blacks are nearly 1.5 times more likely to die from heart disease than Whites, with mortality rates of 322.7 per 100,000 and 219.0 per 100,000 respectively. While Blacks have had rates consistently higher than Whites over the last five years, the rates for Hispanic/Latinos and Asian/ Pacific Islanders were consistently lower than White rates during the same time period. Heart disease death rates for the American Indian/Alaskan Native population are less stable. A rise in death rates in 2001 gave this population the highest heart disease death rate of all groups; since that time, the rates have reduced significantly, with a 2005 death rate below that of Whites.

Heart Disease Death Rates by Race in Michigan, 2000-2005



Stroke rates also depict the disparity in health status that exists for racial and ethnic minorities. The largest disparity exists between Whites and American Indians/Alaskan Natives, with American Indian/Alaskan Natives being 1.4 times more likely to die from stroke than their White counterparts in 2005. The mortality rate for this population is 62.4 per 100,000 compared to Whites who have a mortality rate of 44.2 per 100,000 and Blacks who have a mortality rate of 61.6 per 100,000.

Stroke Death Rates by Race, Michigan 2000-2005

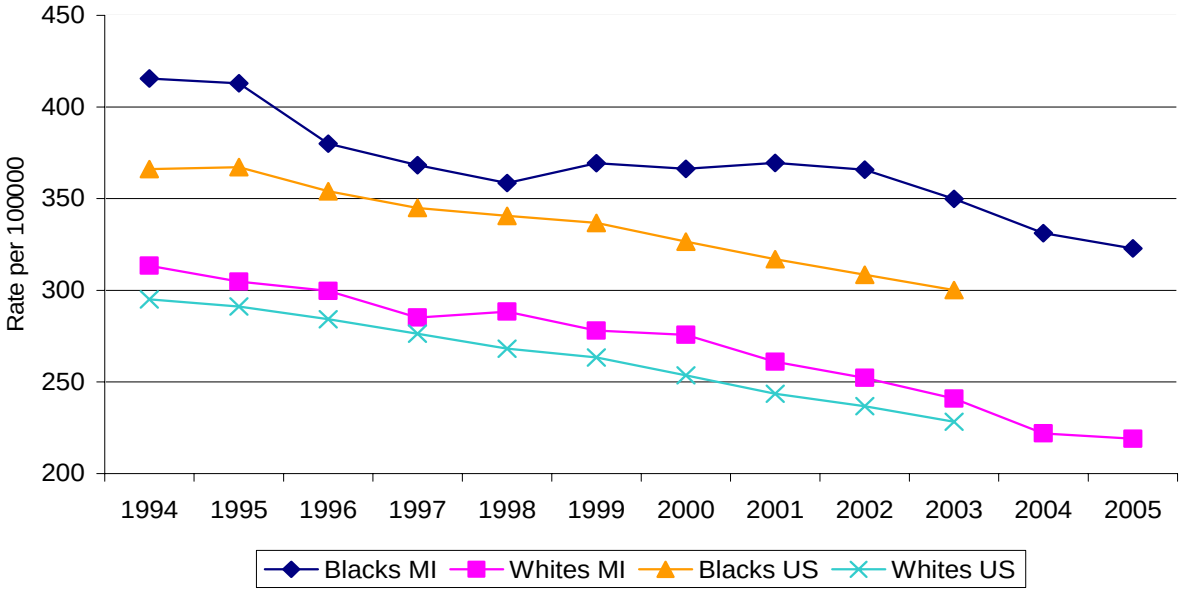


Heart disease and stroke mortality rates could not be calculated for Arab/Chaldean residents due to unstable population estimates; however mortality numbers for this population suggest this population is disproportionately impacted by both heart disease and stroke. The Asian/Pacific Islander community has rates of heart disease and stroke that are significantly less than those rates found among Whites.

How Does Michigan compare with the U.S.?

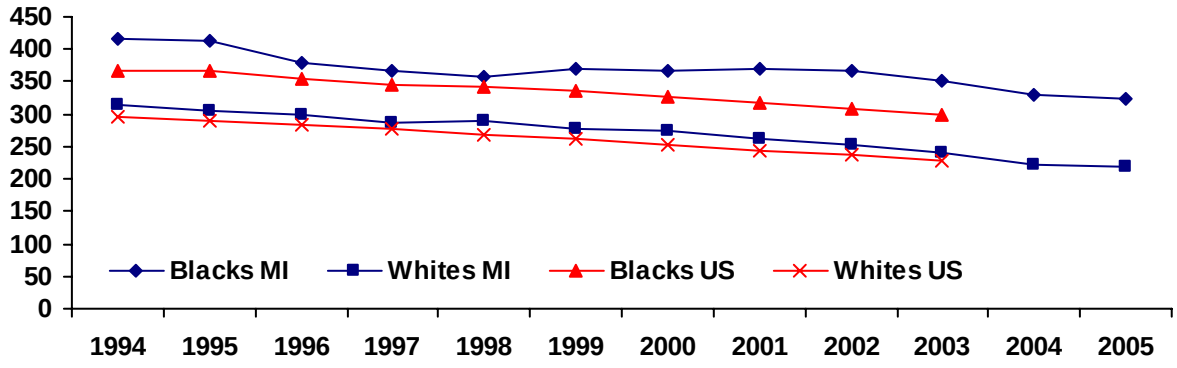
Using 2003 data, the most current data available for the United States, disparities that exist for cardiovascular health in the Michigan are greater than those that exist for the U.S. The Michigan heart disease death rate is greater than the U.S. heart disease death rate, for both White and Black populations (U.S.: 228.2 per 100,000 for Whites, 300.2 per 100,000 for Blacks; MI: 241.0 per 100,000 for Whites, 349.9 for Blacks). Not only are the heart disease rates higher in Michigan, but the disparity between Whites and Blacks is greater as well. In the U.S., Blacks have a 30% higher heart disease death rate than Whites, while in Michigan Blacks have a 45% higher heart disease death rate than Whites.

Heart Disease Death Rates, Blacks and Whites, MI vs U.S. 1994-2005



When looking at disparities in stroke death, Michigan fares better than the United States. This is most likely due to the large impact of the "stroke belt" (approximately 11 states with substantially higher rates of stroke, found disproportionately in Blacks). Blacks living in Michigan are 30% more likely to die from stroke as Whites, whereas in the U.S., Blacks are 45% more likely to die from stroke as Whites.

Stroke Death Rates, Blacks and Whites
MI vs U.S., 1994-2005



What is the Department of Community Health doing to improve this indicator?

The Department of Community Health's main initiative that correlates to decreasing morbidity and mortality in cardiovascular health, is the Surgeon General's "Michigan Steps Up" campaign. This campaign urges Michigan's citizens to "move more", "eat better", and "don't smoke" by outlining what

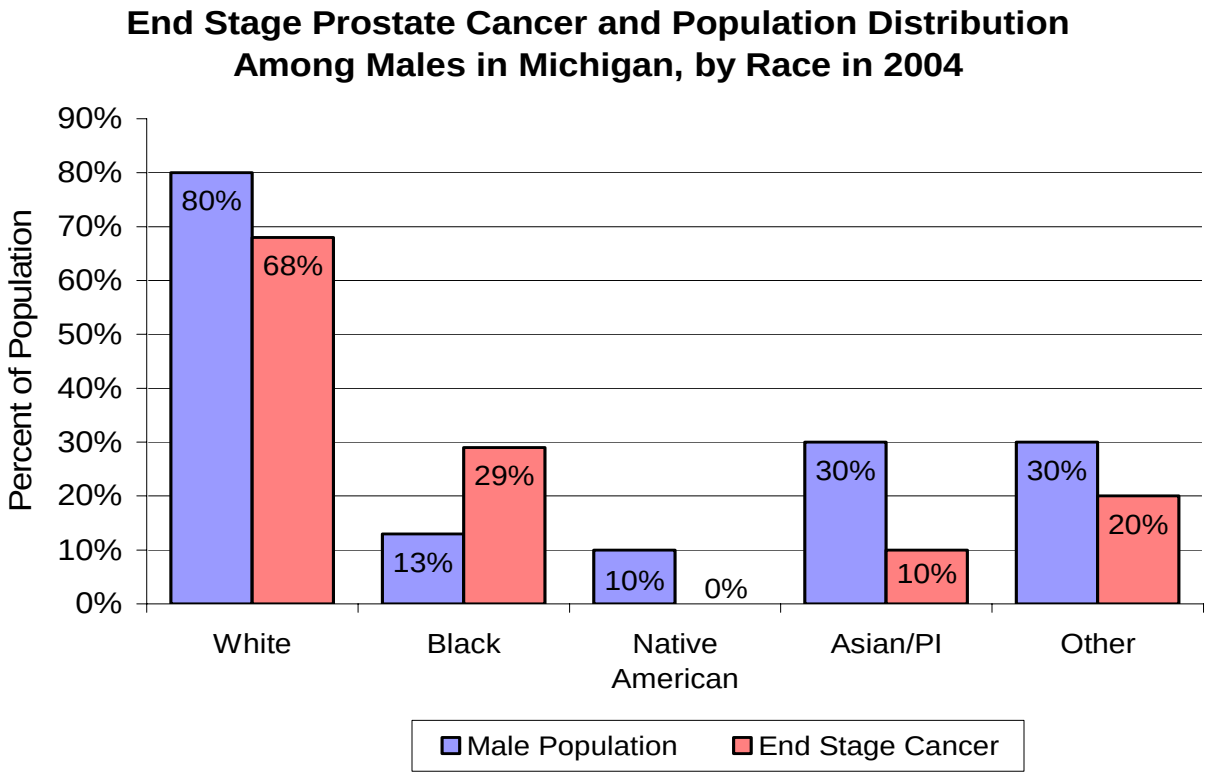
individuals, schools, communities, businesses, and healthcare professionals can do to improve the overall health of the state.

There are also other statewide initiatives aimed at promoting healthy eating, particularly in large urban areas such as Detroit, where fresh fruits and vegetables are not readily available. The Health Disparities/Minority Health Section funds a demonstration project to impact minority health. The project targets adults age 50 and older, primarily African-Americans, living in Detroit. The project activities seek to improve the overall health of participants through reduction/ control of their previously out-of-control hypertension. Participants in the program are demonstrating increased knowledge of hypertension management and increased health-seeking behavior.

Cancer

Cancer incidence rates are higher for Blacks in four cancers traditionally monitored by public health: cervical, colorectal, lung, and prostate. In addition to African-Americans being disproportionately impacted by cancer, they are also getting into care later. Analysis of data by site and stage at diagnosis shows that Blacks are more likely to be diagnosed with cancer at later stages of disease progression.

How are we doing?



Prostate cancer incidence rates for Blacks are more than two times those of Whites; in addition, over 30% of the prostate cancer cases identified in the final stage were among African-Americans.

The survival rate for many cancers improves dramatically with early detection. Mortality rates are higher for Blacks than for Whites for all cancer sites previously mentioned. This is of particular concern with regard to breast cancer where incidence rates are higher among White women, but death rates are higher

among Black women. The total cancer mortality rate for Blacks in 2005 was 225.7 per 100,000, which is nearly 20% higher than the rate in Whites at 186.5 per 100,000. The rate for Native Americans is also disproportionately high, in fact, 10% higher than Whites at 214.3 per 100,000.

Other racial and ethnic groups are not disproportionately impacted in the same magnitude as African-Americans. Cancer incidence and mortality for Asian/Pacific Islanders indicates that the level of cancer seen in these racial and ethnic groups is in proportion to their representation in the population. Due to unstable population estimates in the Arab/Chaldean population, rates cannot be tabulated; however, based on mortality numbers it is suspected that cancer mortality disproportionately affects this population as well.

How Does Michigan compare with the U.S.?

The disparities seen between Blacks and Whites for Cancer deaths in Michigan are similar to those seen across the U.S. Blacks in Michigan are 24% more likely to die from cancer as Whites; the same is true for the U.S.

What is the Department of Community Health doing to improve this indicator?

The Department of Community Health has several initiatives to reduce the disparities that exist in cancer for racial/ethnic minorities, particularly African-Americans. The Department's Cancer Section conducted a study, released in 2005, characterizing cancer in African-Americans, and has interventions targeted specifically at increasing screening in this segment of the population. The Cancer Section has contracts with community agencies in the African-American, Native-American, Asian-American and Arab/Chaldean communities. The Health Disparities Reduction Section has added to the effort by funding a demonstration project in the Arab/Chaldean community to increase knowledge and awareness about cancer facts, increase participation in appropriate cancer screening activities, and increase participation in cancer clinical trials, with the ultimate goal of reducing health disparities in cancer morbidity and mortality among Michigan's diverse populations.

HIV/AIDS

How are we doing?

Black and Hispanic persons in Michigan are disproportionately affected by HIV/AIDS relative to other race/ethnicity groups. Blacks comprise 14% of Michigan's population yet make up over half (59%) of the cases currently living with HIV/AIDS. The MDCH estimates 9,960 Blacks are living with HIV/AIDS in Michigan. The rate of HIV infection among Blacks is 710 per 100,000, nine times higher than the rate among Whites. The Department estimates that as many as 1 of 100 Black males and 1 of 260 Black females may be HIV-infected.

Hispanics comprise four percent of cases and three percent of the population. The MDCH estimates 650 Hispanics are living with HIV/AIDS in Michigan. However, the relatively few cases are distributed among a small population and therefore they have a higher rate (201 per 100,000) than that among Whites. The Department estimates that as many as one out of 350 Hispanic males and one out of 1,030 Hispanic females may be HIV-infected. White persons comprise over one-third (36%) of reported HIV/AIDS cases and 79% of Michigan's population. The MDCH estimates 6,100 Whites are living with HIV/AIDS in the state. However, since these cases are dispersed among a much larger population they have a lower rate of HIV infection (78 per 100,000) than Blacks and Hispanics. The MDCH estimates that as many as one out of 730 White males and one out of 4,970 White females may be HIV-infected.

The following maps below show the distribution of reported HIV/AIDS cases and prevalence rates per 100,000 among Black, non-Hispanic and Hispanic persons by area (county and the city of Detroit) of residence at diagnosis. As suggested above, both the number of cases and prevalence rates should be

considered when evaluating HIV/AIDS data. When an area has a low number of cases, yet has a small population, that area's rate may be high. Likewise, an area with a high number of cases may have a low rate if that area's population is large. Thus, either piece of information alone may not accurately describe the distribution of HIV/AIDS in a population of interest. Furthermore, prevalence rates may become unstable with a small number of cases or a small population. These maps are based on residence at diagnosis, not current residence, and may thus show different patterns than other maps distributed by the MDCH.

Figure 1a: Prevalence of HIV/AIDS Among Black, Non-Hispanic Persons, Michigan Residence at Diagnosis, January 1, 2006

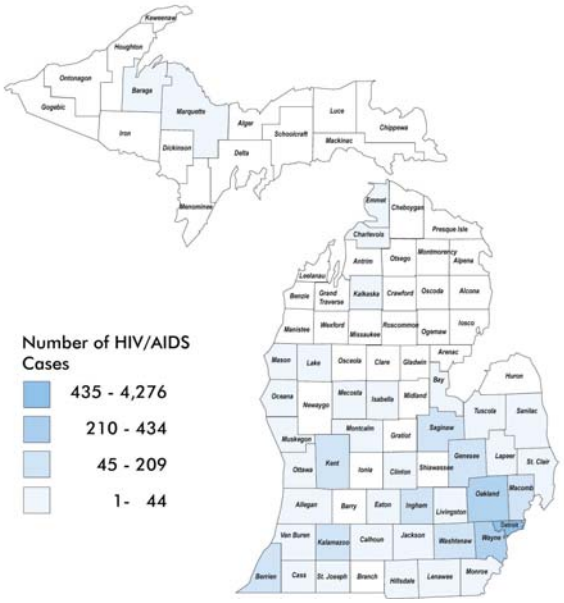


Figure 1b: Prevalence of HIV/AIDS Among Hispanic Persons, Michigan Residence at Diagnosis, January 1, 2006

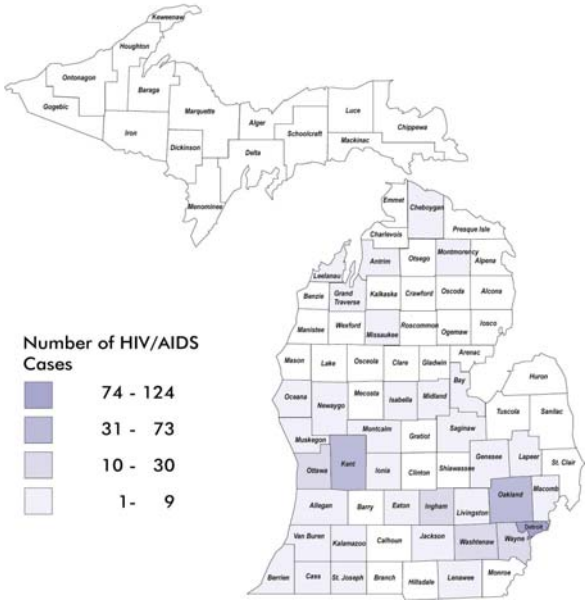


Figure 2a: Prevalence Rate of HIV/AIDS Among Black, Non-Hispanic Persons, Michigan Residence at Diagnosis, January 1, 2006

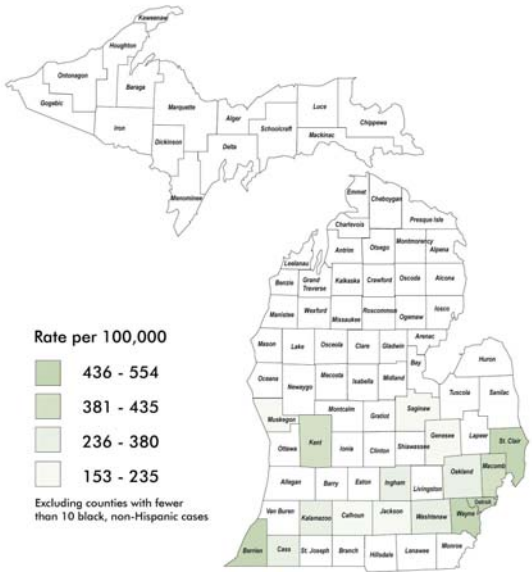
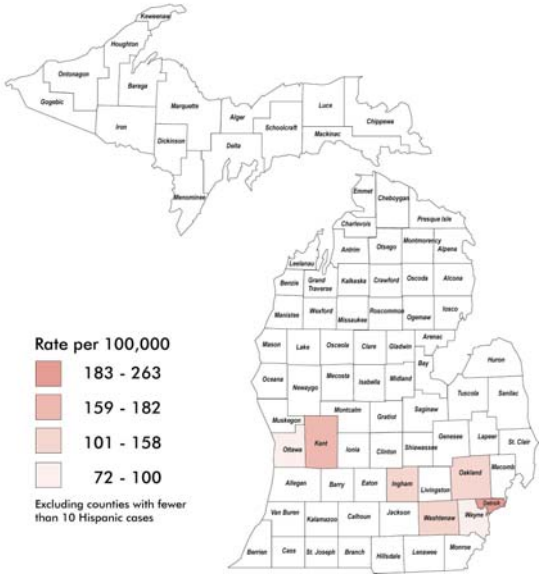


Figure 2b: Prevalence Rate of HIV/AIDS Among Hispanic Persons, Michigan Residence at Diagnosis, January 1, 2006



The areas with the highest prevalence rates of HIV among Black, non-Hispanic persons include: Detroit (575), Berrien Co. (552), Wayne Co., excluding Detroit (516), Macomb Co. (501), St. Clair Co. (473), Kent Co. (452), Ingham Co. (407), Washtenaw Co. (402), Kalamazoo Co. (401), and Oakland Co. (398). In general, the areas with the highest rates surround the I-94 and I-75 interstate highway corridors. The areas with the highest prevalence rates of HIV among Hispanics include: Detroit (278), Kent Co. (217), Washtenaw Co. (192), Oakland Co. (152), Ingham Co. (148), Wayne Co., excluding Detroit (100), Macomb Co. (97), and Ottawa Co. (72). The majority of these areas are in southeast Michigan. Kent and Ottawa Counties, however, are both in southwestern Michigan, a region with a large migrant population.

How Does Michigan compare with the U.S.?

Among all persons living with HIV in the 33 states with name-based HIV reporting, 34% are White, non-Hispanic, 47% are Black, non-Hispanic, 17% are Hispanic, and 1% are other race/ethnicity. Although the proportion of HIV positive persons in Michigan who are White is similar (36%), a larger proportion is Black (59%) and a smaller proportion is Hispanic (4%). Similar race/ethnicity patterns are observed in new HIV diagnoses. In the 33 states with name-based HIV reporting, 31% of the new diagnoses in 2005 were White, 49% were Black, 18% were Hispanic, and 2% were other race/ethnicity. In Michigan, a similar proportion of 2005 HIV diagnoses was White (34%), whereas 60% was Black and 6% was other race/ethnicity.

What is the Department of Community Health doing to improve this indicator?

The Department's Division of Health, Wellness and Disease Control (DHWDC) focuses prevention efforts on early identification of HIV infection through testing, and reduction and elimination of behaviors associated with HIV transmission. The Departments prevention efforts are guided by Michigan's Comprehensive Plan for HIV Prevention developed through an evidence-based planning process. The Plan identifies priority populations to be addressed by Michigan's HIV prevention programming and makes recommendations for the best strategies to address prevention needs. Racial and ethnic minorities are prioritized as targets for prevention efforts. The Plan includes a section that highlights the disproportionate impact HIV/AIDS has on the African-American community.

The MDCH supports HIV testing in local health departments, community health clinics, substance abuse treatment facilities, hospitals and community-based organizations, to encourage and facilitate knowledge of HIV serostatus among individuals at risk for HIV infection and to assist with timely access to care and treatment among those found to be HIV-infected. The Department supports targeted HIV counseling and testing services in 16 high prevalence local health agencies and more than 50 community-based and other non-governmental organizations. Targeted testing efforts are complemented by culturally competent health communication and public information activities designed to ensure awareness of the impact of HIV among targeted communities, to encourage knowledge of HIV serostatus and to provide information on resources for HIV testing.

The MDCH also supports routine HIV testing in selected clinical settings operating in areas of the highest HIV prevalence in the state and which serve primarily African-American populations. Routine testing facilitates knowledge of HIV serostatus among populations who might not otherwise seek HIV testing. The Department provides technical assistance and guidance to providers to assist them in implementing routine HIV testing in clinical settings. In 2006, 67,704 HIV tests were performed in publicly-supported venues. Of these 53% were for African-American clients and six percent were for Hispanic/Latino clients.

The Department supports a range of evidence-based and culturally competent behavioral interventions targeted to communities at greatest risk for transmission/acquisition of HIV. Behavioral interventions are designed to promote adoption and maintenance behaviors to reduce the risk for transmitting HIV (among those who are HIV-infected) or of acquiring HIV (among those who are HIV-negative). Racial/ethnic

minorities receive emphasis in program efforts. DHWDC supports intervention models specifically endorsed by the Centers for Disease Control and Prevention for use with African-American communities including SISTA (Sisters Informing Sisters About Topics on AIDS), for African-American women, BSB (Brothers Saving Brothers) for African-American men, 3MV (Many Men, Many Voices) for African-American men who have sex with men, and Empowerment for younger (ages 18-24) African-American men who have sex with men. In 2006, over 26,000 individuals participated in such interventions, of which 83 percent were African-American.

Infant Mortality

How are we doing?

The overall infant mortality rate for the state increased from 7.6 deaths per 1,000 live births to 7.9 deaths per 1,000 live births. The higher rates of infant mortality experienced in Michigan can be attributed, for the most part, to the high rates of infant mortality in the African-American community. An African-American baby is over three times more likely to die in the first year than a White baby. The disparity between Blacks and Whites declined slightly between 2004 and 2005, but the infant mortality rate for both populations increased, African-Americans at 17.9 and Whites at 5.5.

Due to the high infant mortality rate in the African-American population, infant mortality in other races often goes unmentioned. The infant mortality rate for Hispanic/Latinos is two times higher than the infant mortality rate for Whites. In addition, the gap between Hispanic/Latinos and Whites has been increasing over the past five years. In 2000, the infant mortality rate for Hispanic/Latinos was 1.1 times that of Whites, in comparison with the most current rates of 11.2 for Hispanic/Latinos and 5.5 for Whites in 2005.

How Does Michigan compare with the U.S.?

The infant mortality rate in Michigan is higher than the overall rate for the U.S.; the rate for African-Americans in Michigan is also higher than the U.S. African-American rate. The Black/White infant mortality rate ratio for Michigan has been consistently higher than the rate for the U.S. since 1996. In fact, in 2004, a jump in the infant mortality rate in Michigan caused the disparity seen between Blacks and Whites to be significantly greater than the disparity seen for the country as a whole.

What is the Department of Community Health doing to improve this indicator?

Concentrating efforts on reducing the infant mortality rate for African Americans would reduce the overall infant mortality rate in Michigan. Eleven cities were selected through a series of epidemiological studies. Starting in 2004, each of these cities received funding to start community coalitions, as well as program and epidemiological support.

The Department currently funds a demonstration project called the Tomorrow's Child/Michigan SIDS/Back to Sleep Campaign. This campaign supports Henry Ford Hospital consistently teaching women about the safe sleep message. The goal is to reduce the incidence of deaths among African-American infants attributable to sleep position and sleep environment.

In addition, the state also conducted focus groups among African-American women to get gain a better understanding of the issues and concerns within this population.